

COVID-19 as a Catalyst for Teaching Advance Care Planning

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“Why are we talking about this? Is she going to die tonight? Can’t this wait until tomorrow?”

The plea came from Mrs. M and her family in response to a question about her end-of-life wishes. Mrs. M was a 72-year-old female with advanced gastric cancer, admitted to the oncology service a few weeks before the start of the coronavirus disease (COVID-19) pandemic. She had multiple recent inpatient admissions for treatments and complications related to her advanced cancer and was well known to the medical system given her many comorbidities. We, the admitting team, had assumed that she and her family had discussed her goals surrounding advance care planning (ACP) previously and would be able to further that conversation.

Instead, we felt like intruders, out-of-sync with their expectations for this

hospitalization and her care. Their request made us pause. Could it wait?

With COVID-19, it feels like it can’t. In the hospital, we have seen the rapid deterioration of COVID-19–positive patients, independent of age and comorbidities. Waiting to discuss goals of care, or, as patients have asked, “crossing that bridge when we get there,” is risky. By the time we’ve made it to that theoretical bridge, we are too late.

ACP itself is not new. The Patient Self-Determination Act was passed in 1990 to encourage hospitals to discuss advance directives with their patients. In 2016, Medicare began reimbursing healthcare providers for counseling around ACP. Yet, the proportion of completed advance directives among U.S. adults remains around 30% (1, 2). Even among seriously ill patients, over 70% have never

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addressed advance directives with their healthcare providers (3).

The path to completing an ACP is littered with barriers. Patients are fearful that discussing ACP will cause distress to loved ones (4). Clinicians struggle with their own discomfort and lack of adequate training (3, 5). Resident physicians, in particular, report lower comfort and confidence when discussing death and dying with critically ill patients and their families (6). Among patients and providers, there is a major concern about choosing the “right” time to introduce these conversations: When is the right moment?

COVID-19 has created that moment. It has thrust health care into the national spotlight, with its impact on daily routines, personal lives, and the economy. For over a year, it’s been incorporated into the news we consume, the advertisements we see, and the mandates we follow. In this time of COVID-19, despite all the suffering it has caused, discussions about health care and ACP have been pushed to the forefront (7).

Recently, during a telehealth annual physical exam, my preceptor and I spoke to a young, healthy, 29-year-old female. As part of the healthcare maintenance routine, we asked about exercise, nutrition, vaccinations, and, finally, goals of care. If she became too ill to speak for herself, who would be her voice for medical decisions? To provide rationale for the conversation, we discussed this in the context of COVID-19, hoping to avoid the alarm previously felt on the inpatient service prepandemic. Surprisingly, she was open to the discussion, replying “I get why you’re asking—makes sense with everything going on.”

Shared experiences, such as working through end-of-life planning with friends and family, have been found to positively

affect patients’ willingness to engage with ACP (8). Media, something COVID-19 is no stranger to, can influence perception and uptake of ACP: Consider the increase in ACP engagement following the widely publicized coverage of Terri Schiavo’s story or the influence of fictionalized cardiopulmonary resuscitation on television on patients’ understanding of it (9, 10). If we consider ACP in a behavior change model, with steps of precontemplation, contemplation, preparation, action, and maintenance, as has been discussed, then perhaps COVID-19 has helped move individuals forward to contemplation given “everything going on” (8, 11).

Physicians are part of this shared experience, too. Trainees have seen and experienced more death and dying during the COVID-19 pandemic, with over 500,000 excess deaths noted over the past year (12). They are more likely to work directly with critically ill patients and families, hold conversations about goals of care, and experience firsthand the rewards of early ACP discussions and consequences of delayed or unskilled ACP. Unskilled ACP, we have observed, can damage provider–patient relationships and harm future discussions about end-of-life care. This unique experience, brought on by COVID-19, impacts their day-to-day work and training and can impact how they engage with ACP and, importantly, education around ACP.

According to adult learning theory, adults are more likely to participate and retain information that directly impacts them (i.e., information that is relevant) (13). With COVID-19, discussions and education around ACP have never felt more relevant. These experiences may prime residents for a more thoughtful and involved learning experience and

Table 1. Suggested prompts to use to introduce advance care planning discussions during COVID-19*

Prompts to use with patients
COVID-19 has highlighted the importance of understanding my patients’ health care wishes—I’d love to spend some time thinking about what matters most to you and help talk through any questions you may have.
COVID-19 has changed a lot about how we think about health care and our own health. I’d like to spend some time talking about what is important to you.
COVID-19 has shown us that even young people can become really sick and it’s led a lot of people to think about being hospitalized and even dying. Have you thought about what your wishes would be?
Prompts to use with families and loved ones
This past year has encouraged me to reflect on what is important to me in terms of my life and my health. What conversations have you had with [patient name] around this?
COVID-19 has shown us that we can’t predict the future or plan for everything that might happen. But it can be helpful to think about what is most important to us and our loved ones.
COVID-19 has led to a lot of people thinking about their own and their loved ones’ future and mortality. What discussions have you and [patient name] had?

Definition of abbreviation: COVID-19 = coronavirus disease.
*The prompts in Table 1 were inspired by the talking points discussed in Reference 2.

positively impact their engagement around ACP.

We should take advantage of this moment to teach all providers, including trainees, how to have ACP discussions. Within the internal medicine residency program at Beth Israel Deaconess Medical Center, longitudinal communication courses and protected academic half-days have been integrated into inpatient and outpatient blocks for resident training. The training, which teaches evidence-based skills that emphasize active listening, patient-centered language, self-reflection, and involvement of an interprofessional team, such as palliative care and/or ethics, can improve experiences of both providers and patients (*see* Table E1 in the data supplement for sample curriculum) (14). In fact, dedicated time for educational sessions and simulations has not only been shown to improve residents’ comfort with end-of-life discussions in the

intensive care unit but has also been associated with positive family member experiences (6, 14). These sessions have also been modified to fit the pandemic experience, with greater emphasis on audio and video conferences (*see* Table E2 for additional online resources). Choosing to designate time and space for these sessions now is imperative for all educators.

Patients, as well, are adult learners, and the pandemic has highlighted the relevance of engaging in ACP for them. As patients and their loved ones have become more aware of COVID-19, they have become more aware of the associated risks of illness and mortality and the limits of modern medicine. Our medical experience with end-of-life care (often, the reasons we push for decisions about goals of care) has been shared with society and our patients, and we can capitalize on this moment to normalize and motivate ACP discussions (15).

COVID-19 is our catalyst for more intentional engagement with ACP. Younger age and fewer comorbidities, although important to consider, should not prevent us from introducing the conversation, and neither should our training levels. Death and dying affects us all, and we should normalize the conversation around ACP. We can utilize this moment to provide focused, engaged training and further encourage these conversations with our colleagues and patients (*see* Table 1 for suggested ACP

prompts). We, as providers, patients, and community members, have lived this collective experience, one that has underscored the relevance of ACP, and on a global scale, have moved from precontemplative to contemplative, better able to engage with ACP. Now, this time of COVID-19, is our opening to further the conversation about death and dying. There is no better time than today.

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